

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION, BUREAU OF INSURANCE

REPORTING FORM
COSTS OF THE HMO'S INDEMNIFICATION AND
NONPARTICIPATING REFERRAL PROVIDER ARRANGEMENTS

HMO'S NAME _____

PERIOD ENDING: _____ NAIC CO. Code _____ Group Code _____

This form is to be completed by each HMO licensed in Virginia and submitted with the Annual Statement and each quarterly statement. The costs should be reported on a cumulative calendar year basis.

	* Amount	* % of Total Health Care Expenses
(A) Total health care expenses relating to emergency services	_____	_____
(B) Total health care expenses relating to indemnity benefits (Pursuant to § 38.2-4300, limited to 10% of total health care expenses)	_____	_____
Exclude any:		
-Emergency services included in Section (A) above		
-Nonparticipating referral providers included in Section (C) below		
(C) Total health care expenses relating to nonparticipating referral providers (Pursuant to § 38.2-4300, limited to 5% of total health care expenses or combined with total health care expenses relating to indemnity benefits limited to 15% of total health care expenses)	_____	_____
Exclude any:		
-Emergency services included in Section (A) above		
(D) Total health care expenses relating to participating health care providers, and other health care expenses (including all covered and uncovered expenses)	_____	_____
Exclude any:		
-Emergency services included in Section (A) above		
-Amounts reported in Sections (B) and (C) above		
 Total Hospital and Medical Expenses (Statement of Revenue and Expenses, page 4, Line 18)	 =====	 =====
		100%